Perspective

Adolescents left behind by migrant workers: a call for community-based mental health interventions in Nepal

Nirmal Aryal[1], Pramod R Regmi[1,2,3], Edwin van Teijlingen[1,4,5], Padam Simkhada[4,5,6], Pashupati Mahat[7]

[1]Faculty of Health and Social Sciences, Bournemouth University, Bournemouth, United Kingdom of Great Britain and Northern Ireland, [2]Chitwan Medical College, Tribhuvan University, Nepal, [3]Datta Meghe Institute of Medical Sciences, India, [4]Manmohan Memorial Institute of Health Sciences, Tribhuvan University, Nepal, [5]Nobel College, Pokhara University, Nepal, [6]Centre for Public Health, Liverpool John Moores University, Liverpool, United Kingdom of Great Britain and Northern Ireland, [7]Centre for Mental Health and Counselling–Nepal, Kathmandu, Nepal

Correspondence to: Dr Nirmal Aryal (naryal@bournemouth.ac.uk)

Abstract

Over the past two decades, the unique health needs associated with the second decade of life have been recognized, not least the mental health of adolescents. In parallel, the negative health impacts of parental migration on the children and adolescents who are "left behind" in low- and middle-income countries (LMICs) is beginning to be acknowledged. Nepal is a growing supplier of labour migrants – an estimated 3.5 million Nepali individuals are working abroad – resulting in families being separated and thousands of adolescents being left behind. This can increase psychological and emotional stress and feelings of loneliness and abandonment, and reduce self-esteem among left-behind adolescents, which in turn may have a negative impact on their psychosocial health. Globally, mental health and neurodevelopmental disorders are one of the top three causes of disability-adjusted life-years lost among adolescents. The devastating earthquake in Nepal in 2015 brought into sharp focus the lack of prioritization of mental health services and spurred development of the *Community mental health care package Nepal, 2074* in 2017. This package, together with the upcoming revised National Mental Health Policy, emphasizes the need to (i) ensure the availability and accessibility of basic mental health and psychosocial support services for all; and (ii) facilitate integration of mental health services into the primary health-care system. Recognizing that mental health and psychosocial support services have been predominantly focused on the adult population only, the package includes a component on childhood and adolescent mental and behavioural disorders. It will be essential for policy-makers to ensure that strategies are in place to ensure that left-behind adolescents, especially those who are not in school, have access to these community-based services. Given the paucity of research on mental health interventions among adolescents in LMICs in general, monitoring and assessment of what works for this special group of young people in Nepal may have broader implications for implementation in other countries where migration has resulted in significant populations of left-behind adolescents.

Keywords: adolescents, Asia, developing countries, left behind, migration, stress, young people

Background

Over the past two decades, the unique health needs associated with the second decade of life have been recognized, not least the mental health of adolescents. With respect to burden of disease, self-harm was the third-ranked global cause of adolescent deaths in 2015, with almost half of these deaths occurring in the World Health Organization (WHO) South-East Asia Region. For the same year, self-harm and depressive disorders were, respectively, the third- and fourth-leading causes of disability-adjusted life-years among adolescents in the region.[1]

As reported by the WHO *Mental health atlas 2017*, large disparities exist for child and adolescent services – globally, the median number of child and adolescent mental health beds is less than 1 per 100 000 population and ranges from below 0.2 per 100 000 in low- and lower-middle-income countries to over 1.5 per 100 000 in high-income countries.[2] In addition, among the 78 (out of a total of 177 responses) countries that reported the percentage of government mental health workers providing child and adolescent mental health services, the median provision was below 9%.[2] In Nepal, as in many low- and middle-income countries (LMICs), mental ill-health is still a "taboo", as it is commonly believed to be synonymous with "insanity" and

linked to "sins perpetrated in the past life". This stigmatization prevents adolescents and their parents discussing mental health problems and seeking appropriate treatment.

Labour migration and "left-behind adolescents" in Nepal

For a particular subset of adolescents, parental support is limited, because of migration. Owing to limited employment and other opportunities, international and internal migration are considered as a livelihood strategy for many people. Labour migration is an important phenomenon in Nepal and other LMICs, where one or both parents migrate for work, either internally within the same country or abroad, leaving their adolescent dependents (known as "left-behind adolescents") at home. An estimated 3.5 million Nepali are working abroad, primarily in India, Malaysia and the Middle East.[3] This has led to families being separated, and thousands of adolescents are left behind in Nepal as a spouse, child or sibling.[4] This can increase psychological and emotional stress and feelings of loneliness and abandonment, as well as reducing self-esteem among left-behind adolescents, which in turn may have a negative impact on their psychosocial health.

Evidence on the mental health of left-behind adolescents

Much of the evidence to date on the mental health of left-behind adolescents has been gathered in China and focuses on internal migration. For example, a systematic review in 2014 of studies of children aged under 18 years who were left behind in rural China reported that depression and anxiety in left-behind children was higher than in those not left behind.[5] More recently, a 2018 systematic review and meta-analysis on the health impact of parental migration on left-behind children and adolescents concurred with previous reviews showing that, although parental labour migration might have economic benefits for families, there may also be hidden costs for the health of children and adolescents who are left behind. Again, most of the studies included focused on internal migration in China and the meta-analysis indicated that left-behind children and adolescents have worse outcomes than children of non-migrant parents, especially with regard to mental health and nutrition. Compared with children of non-migrants, left-behind children and adolescents had a 52% increased risk of depression, 70% increased risk of suicidal ideation and 85% increased risk of anxiety.[6] A global school-based student health survey among Nepali adolescents aged 13–17 years showed that lower perceived parental engagement was significantly associated with higher odds for suicide attempt and anxiety in both boys and girls.[7] These findings suggest a need for focused mental health-related interventions aimed at left-behind adolescents.

Psychological health of adolescents in Nepal

Data from the Nepal Adolescents and Youth Survey (NAYS) 2010/11, a nationally representative survey of 11 477 Nepali adolescents (aged 10–19 years), suggested alarming levels of poor psychosocial health: 14% (n = 1570) reported at least one perceived psychosocial problem in the previous 12 months.[8] Of these 1570, this manifested as feeling anxious and restless in 73.1%, feeling "fed up with life" in 39.2%, the occurrence of negative thoughts and loss of self-confidence in 38%, feelings of hopelessness in 32.1% and suicidal ideation in 12%. Another retrospective study, based on police records and thus likely to represent an underestimate, noted that the annual incidence of cases of completed suicide among adolescents (defined as aged 13–21 years) in the country had increased threefold from 5.1 per 100 000 in 2005 to 15.7 per 100 000 in 2009.[9]

Mental health governance in Nepal and the role of community

In recent years, Nepal has made some attempt to improve mental health governance. The National Mental Health Policy 1997 was revised in 2017 by a task force and is under the process of approval.[10] The revised policy aims to provide community-level mental health and psychosocial services at selected places, in collaboration with community-based and nongovernmental organizations. In addition, the *Multisectoral action plan for the prevention and control of non-communicable diseases (2014–2020)* incorporates a mental health action plan, which outlines several community-based strategies, such as scaling up community mental health programmes in all districts; fostering partnerships with influential community groups; integrating mental health in school health programmes; and training female community health volunteers to identify people with mental illness.[11] A community mental health-care package was developed in 2017,[12] aimed at facilitating the implementation of the National Mental Health Policy by integration of basic mental health and psychosocial support services into the community health-care system. Based on the WHO Mental Health Gap Action Programme (mhGAP),[13] it envisages a community role in areas such as awareness and mass sensitization; stigma reduction; implementation of a community informant detection tool; providing basic psychosocial and emotional support; and mobilizing self-help groups.[12]

The role of community in prevention, detection and management of mental illness has become increasingly important in Nepal, owing to the increasing burden of mental health problems and poor availability of skilled mental health workforce. The latest data showed that that there are only 150 psychiatrists, 70 psychiatric nurses and 28 clinical psychologists to serve 28 million people in the country.[10] In addition, mid-level health workers (nurses, health assistants, auxiliary nurses, female community health volunteers), who could play a significant role to reduce the gap in mental health care in the community, receive no or minimal training on mental health in their education, and the training they receive is often without practical exposure.[14] In light of this situation, the Ministry of Health, together with WHO and nongovernmental organizations active in mental health, adopted the mhGAP training course for health workers and doctors. A standard treatment protocol was developed and put in to practice in 2017, together with the mhGAP training package.[12]

A number of studies and programmes in Nepal and in other countries have demonstrated the effectiveness of

a community-based approach to address mental health challenges. For example, use of the community informant detection tool is not only effective for detection of mental health cases in the community,[15] but has also been shown to have increased utilization of mental health services in Nepal.[16] Another good example of community mental health activities is the "community mental health and psychosocial support programme" carried out by the Centre for Mental Health and Counselling–Nepal, which has trained more than 2000 health workers, 8000 female community health volunteers and 250 doctors, and these trained workers have subsequently provided mental health services to more than 50 000 individuals, from government health facilities.[17] In India, a study assessed the effect of a community-based mental health literacy intervention on the demand for care resulting from enhanced mental health literacy. An intervention for depression was led by community-based workers and non-specialist counsellors and done in collaboration with facility-based general physicians and psychiatrists. The intervention was associated with a six-fold increase in the proportion of people with depression who sought treatment.[18]

Nepal has achieved remarkable results from community-based interventions promoting sexual and reproductive health in adolescents and young people, as well as improving maternal and neonatal health outcomes. This track record, as well as existing evidence on community mental health interventions and programmes in Nepal and other countries, suggests that there are promising opportunities for cost-effective and sustainable community-based mental health interventions for adolescents, including left-behind adolescents. The vast majority of the existing evidence on mental health interventions among adolescents comes from high-income countries, of which a significant number have been school-based interventions.[19] However, school-based interventions alone may not be adequate for LMICs like Nepal where the net enrolment rate for secondary school is still low (for example 55.3% nationally in 2017).[20]

Conclusion

Taking account of the existing evidence, we strongly urge that (i) future mental health-related research in Nepal (and also in LMICs) should aim to test the effectiveness of community-based interventions in adolescents; and (ii) in light of the global evidence suggesting heightened mental health risk among left-behind adolescents, this special group of adolescents, particularly those from LMICs, deserves priority in mental health research. Population-wide awareness programmes, psychoeducation, skills training, psychosocial rehabilitation, and psychological treatments are currently the most common community mental health-care activities worldwide.[21] Community-based interventions among Nepali adolescents (including left-behind adolescents) may include empowering local community organizations in relation to adolescent mental health. This would involve mobilizing them to help raise awareness, as well as public discourse activities. Wider use of the community informant detection tool, and raising the participation of service users and family members will be vital. It will also be important to train local mental health professionals on mental health issues for adolescents, including left-behind adolescents, and share good practices in this area. These interventions are likely to be cost effective, acceptable and sustainable. In several LMICs, community-based interventions can help address the double burden of poor health system capacity alongside the increasing number of adolescents (including left-behind adolescents) with mental health problems. We believe that improving the mental health of adolescents in general, and specifically that of left-behind adolescents in LMICs, will contribute significantly to achieving the health-related milestones of the Sustainable Development Goals.[22]

Acknowledgements: We thank the anonymous reviewers for their useful comments.

Source of support: None.

Conflict of interest: None declared.

Authorship: NA, PRR and EvT conceptualized the manuscript. NA wrote the first draft. PS and PM further revised the manuscript. All authors reviewed and approved the final version.

How to cite this paper: Aryal N, Regmi PR, van Teijlingen E, Simkhada P, Mahat P. Adolescents left behind by migrant workers: a call for community-based mental health interventions in Nepal. WHO South-East Asia J Public Health. 2019;8(1):38–41. doi:10.4103/2224-3151.255348.

References

1. Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. Annexes 1–6 and Appendices I–IV. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/handle/10665/255415/9789241512343-annexes?sequence=5, accessed 17 January 2019).
2. Mental health atlas 2017. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1, accessed 17 January 2019).
3. Labour migration for employment: a status report for Nepal: 2015/2016 – 2016/2017. Kathmandu: Ministry of Labour and Employment, Government of Nepal; 2018 (https://asiafoundation.org/wp-content/uploads/2018/05/Nepal-Labor-Migration-status-report-2015-16-to-2016-17.pdf, accessed 17 January 2019).
4. Simkhada PP, Regmi PR, van Teijlingen E, Aryal N. Identifying the gaps in Nepalese migrant workers' health and well-being: a review of the literature. J Travel Med. 2017;24(4). doi:10.1093/jtm/tax021.
5. Cheng J, Sun YH. Depression and anxiety among left-behind children in China: a systematic review. Child Care Health Dev. 2015;41(4):515–23. doi:10.1111/cch.12221.
6. Fellmeth G, Rose-Clarke K, Zhao C, Busert LK, Zheng Y, Massazza A et al. Health impacts of parental migration on left-behind children and adolescents: a systematic review and meta-analysis. Lancet. 2018;392(10164):2567–82. doi:10.1016/S0140-6736(18)32558-3.
7. Global school-based student health survey (GSHS): Nepal. Geneva: World Health Organization; 2016 (https://www.who.int/ncds/surveillance/gshs/nepal/en/, accessed 17 January 2019).
8. Adhikari RP, Upadhaya N, Suwal BR, Shrestha MP, Subedi PK. Factors associated with perceived psychosocial problems and help-seeking practices among adolescents in Nepal. J Popul Soc Stud. 2017;25(1):1–10. doi:10.14456/jpss.2017.1.
9. Mishra N, Shrestha D, Poudyal RB, Mishra P. Retrospective study of suicide among children and young adults. J Nep Paediatr Soc. 2013;33(2):110–16. doi:10.3126/jnps.v33i2.7512.

10. Mental Health Policy, Nepal. Sagun's blog 10 October 2017 Kathmandu: Ministry of Health and Population, Government of Nepal; 2017 (https://publichealthupdate.com/mental-health-policy-nepal/, accessed 17 January 2019).
11. Multisectoral action plan for the prevention and control of non-communicable diseases (2014–2020). Kathmandu: Ministry of Health, Government of Nepal; 2014 (http://www.searo.who.int/nepal/mediacentre/ncd_multisectoral_action_plan.pdf, accessed 17 January 2019).
12. Community Mental Health Care Package Nepal, 2074. Kathmandu: Ministry of Health, Government of Nepal; 2017.
13. mhGAP. Mental Health Gap Action Programme. Scaling up care for mental, neurological, and substance use disorders. Geneva: World Health Organization; 2008 (https://www.mhinnovation.net/sites/default/files/downloads/resource/mhGAP%20Mental%20Health%20Gap%20Action%20Programme%20English.pdf, accessed 17 January 2019).
14. Acharya B, Hirachan S, Mandel JS, van Dyke C. The mental health education gap among primary care providers in rural Nepal. Acad Psychiatry. 2016;40(4):667–71. doi:10.1007/s40596-016-0572-5.
15. Subba P, Luitel NP, Kohrt BA, Jordans MJ. Improving detection of mental health problems in community settings in Nepal: development and pilot testing of the community informant detection tool. Confl Health. 2017;11(1):28. doi:10.1186/s13031-017-0132-y.
16. Jordans MJ, Kohrt BA, Luitel NP, Lund C, Komproe IH. Proactive community case-finding to facilitate treatment seeking for mental disorders, Nepal. Bull World Health Organ. 2017;95(7):531–6. doi:10.2471/BLT.16.189282.
17. Centre for Mental Health and Counselling-Nepal. Community mental health and psychosocial support programme (http://www.cmcnepal.org.np/community-mental-health-and-psychosocial-support-programme/, accessed 17 January 2019).
18. Shidhaye R, Murhar V, Gangale S, Aldridge L, Shastri R, Parikh R et al. The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: a population-based study. Lancet Psychiatry. 2017;4(2):128–35. doi:10.1016/S2215-0366(16)30424-2.
19. Das JK, Salam RA, Lassi ZS, Khan MN, Mahmood W, Patel V et al. Interventions for adolescent mental health: an overview of systematic reviews. J Adolesc Health. 2016;59(4):S49–S60. doi:10.1016/j.jadohealth.2016.06.020.
20. United Nations Educational, Scientific and Cultural Organization. Education and literacy: Nepal (http://uis.unesco.org/country/NP, accessed 17 January 2019).
21. Kohrt B, Asher L, Bhardwaj A, Fazel M, Jordans MJD, Mutamba BB et al. The role of communities in mental health care in low-and middle-income countries: a meta-review of components and competencies. Int J Environ Res Public Health. 2018;15(6):pii:E1279. doi:10.3390/ijerph15061279.
22. United Nations. Sustainable Development Goals. About the Sustainable Development Goals (http://www.un.org/sustainabledevelopment/sustainable-development-goals/, accessed 17 January 2019).